U.S.-Mexico Border Health For a Consistent Policy

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The contrast and diversity between U.S. and Mexico can be seen in the evident spread of both cultures across North America due to transborder movements of people, beliefs, traditions and trade. There is no doubt that the human interaction between these two countries has shaped their history and is determining their present and future. Despite many decades of collaboration between governmental, business and nongovernmental agencies, the 2000-mile U.S.-Mexico border continues to be a mosaic of disparities not only between the two sides of the border but also between the border region and the rest of both countries. For Mexico the northern border symbolizes progress, international corporate investment, manufacturing, the destination for migration and higher living standards. For the U.S., the southern border is represented by stereotypes of poverty, low educational levels, underdevelopment, social segregation and drugs.

U.S.-Mexico border policy decisions must be designed and executed integrally addressing common needs and challenges from both sides of the border and critically recognizing the strengths and weakness of existing political, economic and social conditions.

Nevertheless, the juxtaposition of these two realities creates a unique complexity that should be described and analyzed to better understand the region's challenges and needs. In light of this, U.S.-Mexico border policy deci-

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sions must be designed and executed integrally, addressing common needs and challenges from both sides of the border and critically recognizing the strengths and weakness of existing political, economic and social conditions.

In many cases, U.S.-Mexico border health policy has been characterized by a lack of consistent and realistic approaches to effectively face the increasing number of challenges in a region with significant population flows. Despite relatively high standards of living and life expectancy and low infant mortality rates, institutions, the cost of living, lack of health services, poverty, local public policy design and culture reflect the complexity of effectively satisfying border health needs.

Life expectancy in Mexico's six border states exceeds the 73.5-year national average. In the year 2000, for example, Nuevo León and Baja California continued to have the highest life expectancy in northern Mexico (76.8 and 76.4 years, respectively).[1] According to the 2000 Mexican National Health Survey, the northern border states have the largest percentage of population who perceive their health as "good," led by Chihuahua and Sonora.[2]

Despite some significant improvements in health indicators, others do not provide the most optimal scenario. Mexican border states' infant mortality rate (IMR) is below the Mexican national average of 24.9 per 1,000 live births. The state of Baja California had an IMR of 18.9, leading these northern states, followed by Chihuahua, and Sonora.[3] In contrast, Texas reports an IMR of 5.7 per 1,000 live births, while the U.S. national rate was 6.9.[4]

Tamaulipas had the highest maternal mortality rate (6.67 per 10,000 live births) among northern border states. In fact, this rate has quadrupled since 1990. Tamaulipas is followed by Chihuahua (4.13) and Coahuila (3.6).[5] Despite respiratory and intestinal infections being the first cause of death in the Mexican border states, asthma has increased substantially, especially in Tamaulipas with 488.58 deaths per 100,000 inhabitants and Baja California with 483.6 deaths. The Mexican side has a deficit of 2,125 hospital beds, assuming a need for one bed per 1,000 people. HIV and AIDS cases tend to appear at a higher rate than the national average (4.6 and 4.1 cases per 100,000 inhabitants, respectively).[6] Coahuila, Baja California and Sonora have the highest obesity rates in Mexico, over 30 percent for the first two states, and 40 percent for the third.[7]

Besides health indicators, the differences between U.S. and Mexican institutions and bureaucracies are challenges that cannot be ignored. In Mexico, health care is constitutionally guaranteed. It is administered by the state and federal governments, which provide health and hospital services through institutions like the Mexican Social Security Institute (IMSS), the State Workers Institute for Security and Social Services (ISSSTE) and the Ministry of Health.[8] In this framework, Mexico may have a more consistent health policy than the U.S. because of agency centralization. However, this consistency constricts local innovation. The United States' system may be simpler because the state health departments are given more direct responsibility for overseeing reportable diseases (i.e. tuberculosis, human immunodeficiency virus [HIV]), but these decentralized bureaucracies have produced a more limited health care system.[9]

For example, tuberculosis has been one of the diseases that have received the most attention from border health officials because rates tend to be higher in both countries' border regions than in the interior.[10] Mexico reports 25 cases per 100,000 inhabitants, about eight cases more than the national average.[11]

In addition, tuberculosis is problematic because of the long treatment period (a minimum of six months) and the high rate of migration in the border region. Tuberculosis patients may migrate from one country's health care system to another during treatment. Tuberculosis treatment and prevention differs between U.S. and Mexico health systems with regard to vaccination, diagnostic techniques, treatment regimens and reporting systems.[12] In Mexico, Bacille Calmette-Guerin (BCG) vaccination is a routine part of childhood health care, whereas the U.S. does not use it routinely because it sees the vaccine as useful only among children at a high risk of developing a particularly severe form of the disease. Many U.S. health officials mistakenly treat Mexican-born patients for tuberculosis because the BCG vaccination causes a false positive result on a tuberculosis test.[13] In addition, the U.S. and Mexico have different disease registration protocols and neither side has developed an efficient mechanism for sharing information.[14]

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Another challenge of the difference in health systems is related to the purchase of pharmaceutical products on the Mexican border. According to a survey conducted in El Paso, Texas, patronage of Mexican pharmacies exceeds the expected rate for a young, presumably healthy population. This access is of special concern on the U.S.-Mexico border, where Mexican pharmacies supply a wide range of medications without prescription.[15] As long as there is an opportunity for significant savings by purchasing medications in Mexico, consumers will continue to go to Mexican pharmacies. The availability of cheap medications makes it possible for uninsured people to treat medical conditions.[16]

Addictions are a significant indicator of the general population's health. Ethnicity and ethnic geographic distribution also contribute to explanations of addictions. In the United States, Hispanics are reported to have some of the highest alcohol and tobacco consumption rates.[17] In El Paso, one of the largest border cities, 73.5 percent of the population is Hispanic. El Paso and the border region have the second highest level of acute alcohol risk in the state of Texas.[18] Physical proximity to Ciudad Juárez, Mexico, and its more flexible drinking laws and less expensive alcohol and cigarettes may contribute to the differences between Mexican Americans and non-Hispanic whites.[19]

There is also evidence of a correlation among advertising, health behavior and ethnicity. According to J. Gerard Power, poor ethnic communities are exposed to more alcohol and tobacco advertising than richer and Anglo communities.[20] Despite the fact that the U.S. Federal Communications Commission regulates the advertising of alcohol and tobacco, broadcasters south of the border are not subject to such regulation and communities across the border are exposed to Mexican advertisements.

Binational efforts have been developed to approach and remedy U.S.-Mexico health border challenges. The Pan American Health Organization (PAHO), the Center for Disease Control and Prevention (CDC), the IMSS, Mexico's Ministry of Health and the ISSSTE successfully launched a pilot tuberculosis program on the border. However, the program was limited by institutional and national constraints on administration and implementation. The Mexican government intervened in the project because it claimed that tuberculosis services were out of its jurisdiction. Nevertheless it is important to recognize that these activities reflect a unified institutional effort to provide patient services.[21]

There is also evidence of empowerment that may effectively promote community mobilization for preventive health behavior in the border region. In the Ciudad Juárez-El Paso area, HIV/AIDS programs include education to empower participants with decision-making strategies, with a participatory approach, sharing leadership among staff, patients, family and friends. The program assists participants in developing the knowledge and skills needed to provide HIV/AIDS education, collect relevant information and conduct outreach activities.[22] However, the program's success has been limited to this geographic area.

Other important efforts include the creation of the Mexico-U.S. Health Border Commission, the Binational Project for Epidemiological Monitoring of the Febrile Exanthematic Diseases and Hepatitis; the Binational Committee on Tuberculosis; the Binational Committee on HIV/AIDS; the Binational Committee to Combat Drugs; and the PAHO Sister Cities Program.

Despite the existence of these programs, institutional jurisdiction and local implementation are often limited in scope. Incentives must be put in place to enhance and diversify U.S.-Mexico health research with a deeper appreciation of social, cultural and economic border conditions and the impact of health problems in the population. Research focused exclusively on individual behavior does not explain the vulnerability of population groups. Due to social interaction, the health research agenda must be binational, with the ability to empower the community and a population policy approach. The creation of research mechanisms and funding to design and execute prevention campaigns and develop models of integrated care is determinant for long-term solutions. These mechanisms should mobilize U.S. and Mexican resources, build on regional institutions and account for local dynamics such as migration.

Politicians and others with decision-making ability must be convinced of the complex nature of the U.S.-Mexico border relationship regarding not only

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health issues such as tuberculosis, HIV and vaccination, but also those disparities that may indirectly improve border health conditions such as regulation, consumption, demand and advertising. For example, according to Parietti et al., the danger of Mexican pharmacies selling over-the-counter medications that would require a prescription in the U.S. would be minimized if customers and pharmacy employees were more aware of the side effects of common medicines, counter-indications and drug interactions.[23] In order to have an effective binational program, policy designers and managers must account for these fundamental differences and not expect either side to conform exactly to the other, but include all of the public health agencies in planning and implementation.

Facing and effectively overcoming U.S.-Mexico border health challenges may include sustainable and consistent public policies that harmonize and improve the existing system of epidemiological monitoring. For example, information must be systematized, including gathering, classification and analysis of disease data with integrity, accuracy, timeliness and comparability between both border authorities. It is also fundamental to have trained professionals to estimate the magnitude and importance of health problems in the border population, including the identification of cases and their laboratory diagnosis and follow up.

The democratization of information systems for policy design and implementation, including the transparent use of resources and the participation of the private sector and nongovernmental organizations may prevent the otherwise common misuse of infrastructure and funding due to corruption. Mexican states with the highest emigration rates may cooperate with transit and destination communities in policy and program design and implementation.

Finally, taking into account the aftermath of September 11, U.S.-Mexico health issues may be looked at from a broader perspective. The health of the U.S. and Mexican populations must be considered a component of the North American security agenda for two reasons: 1) the U.S. and Mexico have the world's busiest border, and therefore the highest potential for the spread of disease, and 2) this potential represents an increasing level of vulnerability for local and international biological terrorism. Thus U.S.-Mexico health issues demand sufficient attention and leadership. It may be appropriate to create a sidebar agreement to the North American Free Trade Agreement focused on health, paralleling the existing labor and environmental sidebar agreements. It should establish not only the status of health on the U.S.-Mexico security and political agenda, but also create the ideal forum for increasing and distributing resources for active parties (e.g. civic associations, NGOs, community organizations, etc.) and coordinating the design, adoption, implementation and evaluation of binational health policy. VM

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Notes

[1] Secretaría de Salud, *Indicadores de Resultados* (Mexico City: Dirección General de Estadísticas, Secretaría de Salud, 2001).

[2] Secretaría de Salud and Instituto Nacional de Salud Pública, *Encuesta Nacional de Salud 2000, Cuestionario de Adultos*, vol. 1 (Mexico City: Secretaría de Salud, 2003).

[3] Secretaría de Salud, op. cit.

[4] Texas Department of Health, *The Health of Texas: Executive Summary* (Austin, Texas: Texas Department of Health, 2002).

[5] Secretaría de Salud, op. cit.

[6] Ibid.

[7] Secretaría de Salud and Instituto Nacional de Salud Pública, *Encuesta Nacional de Salud 2000, Cuestionario de Adultos*, vol. 2 (Mexico City: Secretaría de Salud, 2003), p. 46.

[8] Secretaría de Salud, *Indicadores de Resultados* (Mexico City: Dirección General de Estadísticas, Secretaría de Salud, 2001).

[9] Jillian Hopewell, "Cross-Border Cooperation: A Case Study of Binational Tuberculosis Control," J. Gerard Power and Theresa Byrd, eds., *U.S.-Mexico Border Health. Issues for Regional and Migrant Populations* (Thousand Oaks, California: Sage Publications), p. 90.

[10] Ibid., p. 93.

[11] Secretaría de Salud, op. cit.

[12] K. Castro, "U.S. Strategies for Tuberculosis Control: A Focus on the Mexican Immigrants" (paper read at the U.S.-Mexico Border Tuberculosis Review meeting in El Paso, Texas in 1994), p. 93.

[13] Ibid., p. 95.

[14] Pan American Health Organization, *Tuberculosis Control Program* (El Paso, Texas: PAHO, 1993).

[15] Ellen M. Parietti, Joao B. Ferreira-Pinto and Theresa Byrd, "Easy Access to Contraceptives Among Female Adolescents in a U.S.-Mexico Border City," Power and Byrd, eds., op. cit., p. 119.

[16] Ibid., p. 136.

[17] Gerard J. Power, "Alcohol and Tobacco Advertising in the Border Region," Power and Byrd, eds., op. cit., p. 80.

[18] Texas Department of Health, *Selected Facts for El Paso County* (Austin, Texas: Texas Department of Health, 1995).

[19] Gerard J. Power, op. cit., p. 83.

[20] Ibid.

[21] Jillian Hopewell, op. cit., p. 99.

[22] Jesús Ramírez-Valles, Marc A. Zimmerman, Enrique Suárez and Graciela de la Rosa, "A Patch for the Quilt: HIV/AIDS, Homosexual Men and Community Mobilization on the U.S.-Mexico Border," Power and Byrd, eds., op. cit., p. 114.

[23] Parietti et al., op. cit.